UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

# LETAIRIS (ambrisentan)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477**

## CRITERIA:

- Age limit: 18 and above
- Documented diagnosis of Pulmonary Hypertension

## AUTHORIZATION:

1 year

## RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

5/12/08